INFORMATION SHEET

Name: ____ Birthdate: ___________________ Age: __________

Address: ____ City: _____________________ Zip: ___________

Telephone: _________________________________ Preferred Contact Number: __________________________

Social Security: ______________________________ Sex: ___M ___F Marital Status:(Circle) S M W D

Employer: ____ Employer Phone: ____________________

Address: ____ City: ___________________ Zip: ___________

Occupation: ____

Race: _________________ Preferred Language: __________________ **Email:** __________________________

Pharmacy (Name/City/Street):____

Spouse Name: ____ Spouse Birthdate: __________________

Social Security: ____

Employer: ____ Employer Phone: ______________________

Primary Physician / Referring Doctor: ____

Other Physicians treating you currently: ____

Person to contact NOT living with you (in case of emergency):____

Emergency Contact Phone: ________________________________ Relationship: _________________________

Person(s) you authorize us to discuss medical care or appointments with:___________________________________

Person(s) you do NOT want information to be released to: ____

Insurance Information: (Please do not fill this out if your injury is work related).
**It is the responsibility of the patient to inform the office of all health insurance coverage.
**It is also the responsibility of the patient to notify the office of any insurance changes.

Primary Insurance Company: _______________________________ Policy/ID#___________________________

Insurance Company Address: _____________________________________ Phone: _______________________

Name of Insured: ____ Birthdate of Insured: ___________________

Secondary Insurance Company: _____________________________ Policy/ID#___________________________

Address: ____ Phone: __________________________

Name of Insured: ___________________________________ Birthdate of Insured: _________________________

Were you referred to our office by your employer (or their insurance company) for a work related injury? ___________

Please remember that insurance is considered a method of reimbursing a physician for services provided and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible, co-payment, or other balance not paid for by your insurance. Payment for services is due at the time they are performed.

I understand that any services provided are medically necessary and payable only if I am an eligible member of the insurance company listed above. I understand that if I am not eligible with the insurance company or medical group referring me to Mission Surgical Clinic, or if the service is for a non-covered benefit, or if I request a service beyond what is approved by my insurance that I may be billed for the services rendered.

I authorize and request my insurance company to pay directly to my physician, the amounts due in my pending claim for medical or surgical care.

I hereby authorize Mission Surgical Clinic to obtain my prescription history from outside sources.

I hereby authorize Mission Surgical Clinic to communicate protected health information regarding my care via email.

I hereby authorize Mission Surgical Clinic to use data about my treatment for research and publication purposes; furthermore, I understand that no identifying information would be released without my consent.

I understand that I am financially responsible for all charges regardless of insurance status, and may be billed for any services that are not covered by my plan. I am aware that all accounts will be subject to finance charges.

Signature:____ Date: ___________________